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Patient-Centred vs Person-Centred: The Role of Documentation in Mental Health Services

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The recent global political climate highlights the fact that with new leadership, comes new policies and new ways in which people are seen and unseen. Reflecting on this, it is now more apparent than ever that all voices and lived experiences are valued. The Journal of Recovery in Mental Health will continue to be a showcase of diverse points of view that position identity, belonging and connection at the forefront. Individuals are seen as having strengths and no “one” narrative or point of view is seen as more important or the “truth” of the human experience over any other. With this in mind, it is quite fitting that one article in particular in the current issue highlights how policy change can influence one’s sense of self and identity in a profound, and potentially harmful way.

In their article, Høgås, Josephsson and Alsaker provide a thoughtful analysis of how a local policy change regarding documentation might affect individuals accessing a low threshold mental health service. In particular, the authors explore how current users of the service see their engagement via photos with corresponding narratives and how these identities may shift as a result of the services requiring a professional to document on them as “patients.” The concern is the shift from being citizen with agency and a voice within a low threshold service to a patient identity, seen as a passive recipient of care.

Recovery Colleges are examples of low threshold services that have proven to transform identity from patient to person or learner. From personal experience launching a Recovery College within a Canadian hospital, it was a challenge at the outset for hospital staff to get past the lack of documentation in the college (Arbour & Stevens, 2017). Before launching the Recovery College, a series of information sessions were developed and presented to allay staff concern about the inability to document potential risks or “decompensation” of individuals participating in the college. In many instances, staff were genuinely concerned that the Recovery College was not consistent with the College of Nursing practices. However, once staff understood that the colleges were not treatment nor did they replace treatment, some of our biggest detractors became our biggest allies. Had documentation been introduced into the college, students’

identities would remain that of a “patient” rather than artist, musician, author, or advocate. Therefore, it would seem that Høgås et al. concerns are valid.

However, documentation in healthcare is necessary. In some instances, institutions have leveraged an electronic medical record to ensure timely and collaborative communication across disciplines and even organizations. This information is also important to track users of services, establish needs of special populations, and gauge treatment performance. While the argument thus far has been that documentation can lessen personhood and increase the patient identity, there are instances in my personal experience that demonstrate that the lack of documentation augments the “patient” identity. For example, a recent project required leveraging data contained in an electronic medical record to determine any trends or needs in an adolescent population seeking outpatient mental health services. The goal was to leverage certain identity demographics to ensure program offerings were gender and culturally informed. However, when the data was pulled, it revealed the overwhelming majority of demographic information, including racial, cultural, and religious information, was not captured. The only consistent variables of use were age, sex and diagnosis. As a result, we knew very little about the young people accessing these services other than their “patient” information (i.e., diagnosis). The identity of these adolescents was reduced to their mental illness. In this instance, increased documentation would position these adolescents as more than their patient identity.

For better or worse, documentation is a part of mental health care delivery. It is clear that there is an impact of documentation depending who is narrating and who decides the “story” being documented. A large part of recovery in mental health is to have individuals identify goals that are deeply personal in nature rather than the professional led goals that are usually avoidance in nature (i.e., avoiding substance use, avoiding relapse, avoiding falls, or infections). Documentation tends to be a ubiquitous part of care delivery; however, it does merit some questioning of its practice. Why are we documenting and for whom? It’s rare for patients to have copies of their own care plans even though they are most impacted. It should also be noted that the sheer requirement of documentation in the inpatient mental health setting detracts from care providers’ ability to engage with the patient directly. I recall one social worker explaining to me that she spent the whole day in the community with one of her patients and really enjoyed the ability to engage meaningfully. However, she felt somewhat punished once returning to the hospital as all her documentation requirements were waiting for her.

Needless to say, the potential detrimental impacts of documentation on identity and on practice is not a problem that will likely be solved any time soon. However, the discussion of its utility and impact is important and an interesting addition to this journal’s issue. As always, we welcome further discussions and case studies in upcoming issues. We are currently accepting submissions from all points of view

including those with lived experience, those of caregivers, and innovative mental health research and practice to add to the fruitful discussion.

References

Arbour, S. & Stevens, A. (2017). A recovery college in Canada: An innovative means of supporting and empowering individuals with severe mental illness. *Canadian Journal of Community Mental Health*, 36,3, 59-63. <https://doi.org/10.7870/cjcmh-2017-017>